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FACTORS AFFECTING REFUND OF BPJS CLAIMS IN INPATIENT CASES AT RSUP X

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ABSTRACT

Problem: Incomplete administration of claims files and inaccurate diagnosis codes are inhibiting factors in verifying claims files. From the results of initial observations of 10 samples of claim files for inpatient cases submitted to BPJS, it is known that 7(70%) were approved and 3(30%) were returned due to no confirmation of the Anatomic Pathology results, no X-ray results and incorrect diagnosis codes. resulting in delays in the claim payment process which causes material losses for the Hospital. **Objective:** To find out the factors that influence the return of BPJS claims for inpatient cases. **Method:** This type of research is observational with a descriptive design. The population and sample in this study were 130 claim files for the fourth quarter of 2022 which were returned to the hospital upon first submission. The data used is secondary data obtained by observation using an observation sheet, then the data is processed and analyzed univariately using a frequency distribution.
Results: Incomplete administration of claims files was 59(45%) and inaccurate diagnosis codes were 71(55%). It is recommended that hospitals make efforts to increase the accuracy of diagnosis codes through training, supervision and regular evaluation to minimize the occurrence of returned claims.

Keywords : Adminitration; Diagnosis Code; Klaim File; Kode Diagnosa; Return

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1. INTRODUCTION

One of the efforts taken by the government to improve health is the existence of a legal entity formed to administer the public health insurance program which is then called the Health Social Security Administering Body (BPJS), which is an important implementation of the National Health Insurance (JKN).

Republic of Indonesia Health Meterial Regulation Number 71 of 2013 concerning Health Services in National Health Insurance states that health insurance is a guarantee in the form of health protection so that participants obtain health care benefits and protection in meeting basic health needs provided to everyone who has paid contributions or has had their contributions paid. by the government, with the prospective payment method applied, it is a payment made for health services where the amount is known before the health service is provided.

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The prospective payment pattern is known as casemix, namely grouping diagnoses and procedures with reference to similar/same clinical characteristics and the use of similar/same treatment costs, grouping is done using grouper software that is familiar with INA-CBG's where claims will be paid by BPJS (Ardhitya, 2015).

In line with the Regulation of the Minister of Health of the Republic of Indonesia Number 28 of 2014 concerning Guidelines for Implementing the National Health Insurance Program, matters that influence the BPJS claim verification process include the completeness of the claim file and the accuracy of the diagnosis code and the time for submitting the claim in accordance with the provisions. Completeness of files for inpatients includes complete medical record information which must be signed by the doctor in charge of health services. Apart from the completeness of the files, another thing that influences the smoothness of the BPJS claim process is the suitability of the code between the claim sheet (BPJS) and the medical resume (hospital). The resulting diagnosis and action codes must comply with ICD-10 and ICD-9-CM.

According to the Ministry of Health of the Republic of Indonesia in 2008 concerning Technical Instructions for Claim Administration and Verification of the National Community Health Insurance Program, the complete documents for submitting a claim are referral letters, examinations, diagnostic support services and medical procedures authorized by the responsible doctor. Based on the Regulation of the Minister of Health of the Republic of Indonesia Number 903/Menkes/Per/2011 concerning Guidelines for Implementing the National Community Health Insurance Program, if one of the requirements is missing or the items are not filled in completely this will result in the success of the claim process.

Approval of claims submitted to BPJS is influenced by the completeness of administration and accuracy of diagnosis and action codes between claim sheets (BPJS) and medical resumes (hospitals) in accordance with ICD-10 and ICD-9-CM, completeness of claim file requirements and completeness of medical information which must be signed by the Doctor in Charge of the Patient (DPJP). In documenting medical records, diagnosis and action codes in ICD-10 and ICD-9-CM are important data used as a reference in determining the cost of health services. Medical records must be coded correctly, completely and precisely and done in a timely manner so that they can be used for making medical record decisions (Oktavia, 2017).

Based on the Decree of the Minister of Health of the Republic of Indonesia Number HK.01.07/Menkes/312/2020 concerning Professional Standards for Medical Recorders and Health Information, it is explained that one of the main competitions for medical recorders is the classification and coding of diseases. Coding officers must be able to take responsibility for the quality of the code produced. The coding results must be complete and reflect the conditions and actions received by the patient.

According to Purwanti (2016), in her research, the quality of coding results depends on the completeness of the diagnosis, the readability of the doctor's writing and the professionalism of the coder. Determining and writing a diagnosis that must be in accordance with ICD-10 is the doctor's responsibility, while coding officers must communicate with each other well in order to produce a correct and accurate code of the disease.

If the diagnosis and writing of the diagnosis included in the medical record file is incorrect, it can affect the accuracy of coding and impact the cost of health services. This can indicate the ineffectiveness or inaccuracy of managing health service data in health service facilities (Made et al, 2020). Apart from that, coding inaccuracies also affect the smoothness of the claims process, causing the submitted claim files to be pending so that the submitted files are returned by the BPJS verifier to the hospital for correction.

The Central General Hospital is a class A government-owned hospital which has the most complete health services in the South Sumatra, Jambi, Bengkulu and Lampung regions and is a National Referral Hospital based on Minister of Health Regulation Number: HK.02.02/Menkes/390/2019 dated 17 October 2019. RSUP has achieved KARS plenary accreditation in 2019 and JCI International accreditation in 2016.

A preliminary survey conducted by researchers at RSUP SOP for Claim File Verification and SOP for Submitting Claims. Based on the BPJS Inpatient Report, it is known that the number of BPJS inpatient case visits over the last 2 years has increased, this can be seen in the following data, namely 20,142 cases in 2021 and 31,559 cases in 2022 with the highest number of cases in Quarter IV, namely 8,046 cases.

The results of initial observations carried out on 10 samples of claim files for inpatient cases submitted to BPJS Health showed that 7 (70%) were approved and 3 (30%) were rejected because 1 file did not have confirmation of the results of Anatomical Pathology (PA), 1 file there were no x-ray results and 1 file had an incorrect diagnosis code. Based on the results of direct observation by looking at the claim file, it was discovered that the former claim was pending so the BPJS verifier returned it to the hospital for repair, due to incomplete claim file requirements in the form of no confirmation of PA results, no x-ray results and incomplete medical resume contents. which resulted in the diagnosis code being written being doubted by the BPJS, and the diagnosis code being coded not in accordance with the coding manual criteria. Apart from that, officers were not careful in coding and verifying the claim file before submitting it to BPJS, which resulted in the claim file being returned for correction.

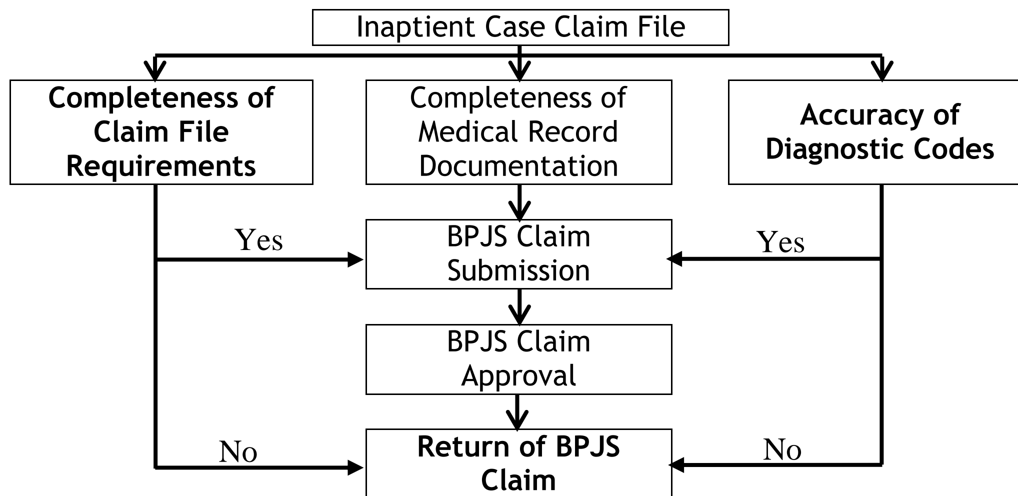
The completeness of claims files and accuracy in coding an illness and action is very important because it relates to the approval of claims submitted to BPJS and the financing of health services, both self-borne and BPJS. Based on the results of interviews with casemix officers, it was discovered that the files returned by the BPJS verifier were due to the code created by the coder on the medical resume sheet during claim verification which turned out to be different from the code from the BPJS verifier. The coder has created a code according to the diagnosis written by the doctor. However, during the verification results of BPJS claims during the coding analysis, several codes were found that were inaccurate and did not comply with BPJS regulations and minutes, so they were pending and returned to the hospital for repair.

Indawati (2019) in her research said that claim files were returned to the hospital because the coding information in the claim file was inaccurate, including the absence of supporting examination results that supported the diagnosis. This is because the completeness of the claim file and the accuracy of the code are the main requirements for passing verification.

Claim files that are not approved by BPJS and returned to the hospital have an impact on delays in the claim payment process, causing material losses, reducing the quality of medical record services and the casemix team's workload will increase (Irmawati et al, 2018). Therefore, before a claim is submitted to BPJS, it is very important for the hospital's internal verifier to re-evaluate the completeness of the claim file and the accuracy of the code before submitting it to BPJS so that the claim is not returned and is immediately verified by BPJS.

Considering that there is often a pending claim file for inpatient cases at the initial submission every month, because the absence of PA or X-ray examination results raises doubts about the diagnosis and diagnosis code written in the claim file, thus having an impact on returning the claim file to be completed/corrected, then The author is interested in conducting research on factors that influence the return of BPJS claims for inpatient cases.

2. THEORETICAL FRAMEWORK



3. METHODOLOGY

The type of research is observational with a descriptive design. The population and sample in this study were 130 claim files for the fourth quarter of 2022 which were returned to the hospital upon first submission. The data used is secondary data obtained by observation using an observation sheet, then the data is processed and analyzed univariately using a frequency distribution.

4. RESULTS AND DISCUSSIONS

a. Incomplete Administration of Inpatient Case Claim File at RSUP X

Tabel 1. Incomplete Administration of Inpatient Case Claim File at RSUP X

Claim File Administration	Amount	Percentage (%)
Complete	71	55
Incomplete	59	45
Amount	**130**	**100**

Source : Processed Secondary Data, 2023

Completeness of claims file administration based on the results of observations and interviews with the person in charge of inpatient casemix shows that the files required for submitting a BPJS claim include Participant Eligibility Letter (SEP), individual patient report, patient support report, medical resume, JKN verification form (INA-CBG's) , certificate (hospitalization order, emergency letter, referral letter) and patient identity (KTP and BPJS card). Based on research results, it was found that 59 (45%) of the files were incomplete in the administration of claim files for inpatient cases submitted to BPJS.

Based on the results of observations and interviews with the person in charge of inpatient casemix, the claim submission files were incomplete for administration because 2 files did not contain medical resumes, 4 files had medical resumes but contained incomplete content items, 2 files had unclear laboratory results, 2 files were missing doctor's assessment and 1 file did not contain a letter of cancellation of action. This incomplete administration of the claim file occurred because the officer was not careful in verifying the completeness of the claim file before it was

submitted to BPJS by a maximum of the 5th of each month, resulting in the claim file being returned to the hospital for correction.

Incompleteness of claim documents, especially in supporting files or patient support files which are part of the completeness of documents and claim procedures, is due to the lack of attention and understanding of officers regarding the completeness of medical record documents (Malonda et al, 2015). This is one of the reasons for the return of claim files because based on the 2004 BPJS Health Claim Verification Technique Instructions, it is explained that BPJS verifiers have the right to confirm to officers that if there is no evidence, the claim will be returned to the hospital to be completed or corrected (Irawati et al, 2018).

Lack of supporting sheets and medical resumes will have an impact on the accuracy of the code that will be enforced, the validity of billing and the calculation of patient care costs because the supporting sheet is proof that the patient has provided additional services and will cause the file to be unclaimed and must be returned to be completed. In line with Pitaloka & Ningsih (2021), the completeness of the claim file is a consideration for the smoothness of the BPJS claim process, such as not attaching a supporting report sheet to the BPJS claim submission requirements file for inpatients, while cases of diagnosis of the action or procedure carried out require a supporting report so that the verifier BPJS asks for completeness by returning the claim file.

Delays and returns of claim files cause claim payments to be postponed and hospital cash flow to decrease, thus affecting hospital operational funds because almost 90% of hospital patients are BPJS patients (Pitaloka & Ningsih, 2021).

The patient's medical record file is a very important factor in claiming BPJS. The completeness of the patient file administration shows the accuracy of providing guarantees by BPJS. BPJS claims officers must check the administrative completeness of claim files to ensure that BPJS provides funding appropriately and in accordance with the specifications for the types of treatment (Rahmatiqa et al, 2020).

b. Inaccuracy of Diagnostic Codes for Inpatient Cases at RSUP X

Tabel 2. Inaccuracy of Codes for Inpatient Case at RSUP X

Diagnosis Code	Amount	Percentage (%)
Accurate	59	45
No Akurat	71	55
Amount	**130**	**100**

Source : Processed Secondary Data, 2023

Inaccuracies in the diagnosis codes for inpatient cases submitted to BPJS from the research results were discovered in 71(55%) files. Based on observations and interviews with the person in charge of inpatient casemix, it was discovered that when determining the code, the coding officer found it difficult to read the doctor's writing in the form of unclear writing of the diagnosis made by the doctor so they had to clarify with the DPJP, however, clarifying often took quite a long time because DPJP schedule which is not always available at the hospital. The coding officer contacts the DPJP when the DPJP has a schedule at the hospital so that to carry out coding the coding officer must look at the history of treatment, medication, symptoms on the anamnesis sheet and physical examination.

In line with Susanti's research (2018) which states that when deciding on a BPJS claim the coding officer encountered difficulties related to the diagnosis made by the doctor and abbreviations that were difficult to understand, so the coding officer had to clarify with the doctor, and when the clarification process was unsuccessful, the

coding officer using Rule MB1-MB5 to reselect or reselect the main diagnosis code (Hamid, 2013).

Apart from that, in the process of determining the diagnosis code, the coding officer only codes by looking at the diagnosis without reading the results of the supporting reports and medical resumes that support the diagnosis. Ningtyas, et al (2019) in their research stated that the information needed to support the accuracy of the diagnosis code for childbirth cases includes a resume sheet (discharge summary) which functions to determine the diagnosis made by the doctor, a laboratory examination results sheet which functions to determine certain conditions in the patient, a sheet The results of radiographic examination (USG) serve to determine the condition of the fetus, informed consent and operation reports (Susanti, 2018).

This is in line with the results of research by Alik (2016) which states that the inaccuracy of coding obstetric diagnoses is caused by, among other things, the writing of diagnoses being less clear and less specific, the doctor's writing being difficult to read and using abbreviations making it difficult for coding officers to assign codes and coding officers often do not read the records. completely medical like (not reading supporting reports, anatomical pathology results, operation sheets) but only looking at the diagnosis in the discharge summary (medical resume) (Ningtyas et al, 2018).

According to Meilany (2018), the factor in the accuracy of giving a diagnosis code is the results of medical supporting examinations. The completeness of the results of medical supporting examinations influences the accuracy of assigning diagnosis codes because they can be used as supporting information if the diagnosis determined by medical personnel is unclear or incomplete (Alik, 2016). A code can be declared correct if it is in accordance with ICD-10 and ICD-9-CM based on a diagnosis supported by supporting information such as laboratory results and anatomical pathology results (Meilany, 2018).

Apart from that, a factor that influences the accuracy of providing a diagnosis code is the completeness of filling in the medical information. In the Regulation of the Minister of Health of the Republic of Indonesia Number 27 of 2014 Chapter IV part H, it is explained that the completeness of the contents of medical records written by doctors will really help coding officers in providing appropriate diagnosis codes and actions or procedures. This is in line with research by Wariyanti (2014) which states that completeness of medical information and accuracy of medical record documents is very important, if the medical information in a medical record document is incomplete then the resulting diagnosis code will be incorrect (Indawati, 2019).

The implementation of diagnosis coding must be complete and precise in accordance with ICD-10 directions. The accuracy of diagnosis and action codes greatly influences the quality of statistical data and payment of health costs using the casemix system. In line with research by Gifari & Ariyanti (2019), determining an incorrect diagnosis code can be a problem so that BPJS claims cannot be paid because they violate the provisions set by BPJS. If this continues to happen, the further impact that will be seen is a decrease in hospital income and will have an impact on hampered hospital operations (Wariyanti, 2014).

The impact that will occur from inaccurate delivery codes will affect the costs of care and medicines used/consumed as well as affect the process of submitting claims to BPJS. In line with Ayu's (2012) research, the impact of discrepancies in coding a diagnosis will affect claims for treatment costs, hospital administration and the quality of services available at the hospital. According to Alik (2016), in his research, the accuracy of enforcing diagnosis codes affects the cost of health services that will be provided, this can cause losses for hospitals because payment of

claims based on INA-CBG's is determined from the coding results determined by the coding officer (Ningtyas et al, 2019).

5. CONCLUSION

The completeness of the claim file and the accuracy of the diagnosis code have an important role in the smooth verification of claims and are the basis for approving the billing of verification costs by BPJS to the Hospital so that the service costs that have been incurred will be paid on time by BPJS and will have a good impact on the Hospital because it will not experience difficulties in operational costs or incurring losses.

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